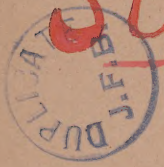

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LAPAROTOMY PRESENTING FEATURES OF UNUSUAL INTEREST.

BY

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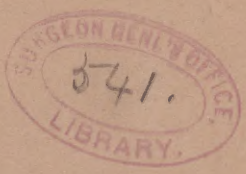
Reprinted from the Boston Medical and Surgical Journal of April 14, 1892.



BOSTON:
DAMRELL & UPHAM, PUBLISHERS
No. 283 Washington Street.
1892.

S. J. PARKHILL & CO., PRINTERS
BOSTON

CASES OF LAPAROTOMY PRESENTING FEATURES OF UNUSUAL INTEREST.[1]

BY CHARLES P. STRONG, M.D.

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MANY of the operations performed by me during the last eight years, involving opening of the abdomen for various reasons, have been reported; but there remain others, presenting certain points of interest, which have not been reported. I wish to emphasize and illustrate by some cases the following points:

The difficulties of diagnosis of abdominal growths.

Results of removal of the uterine appendages in their influence upon menstrual disorders associated with reflex symptoms.

Change, as of senile atrophy, rapidly following the removal of diseased ovaries.

Certain unexplained results; for example, decrease in tumors with subsidence of symptoms following laparotomies which were but little more than exploratory incisions.

The difficulties of diagnosis of abdominal growths.

Mrs. L. S., thirty-eight. Married six years. One miscarriage at six months, five years ago, since which time menstruation has been more abundant.

Examination under ether December 10, 1889. The patient had previously to this time been under treatment in the out-patient department for hæmorrhages, very constant and very profuse, confining her to bed for two weeks at a time. During the past three months these hæmorrhages had been almost without

[1]Read before the Obstetrical Society of Boston, February 13, 1892.

cessation. She entered with a diagnosis of submucous fibroid. A mass the size of a pigeon's egg, firmly connected to the uterus, was found on the left. In the median line was felt a mass extending up to the umbilicus, the pubic outline of this induration illy defined. The fundus of the uterus could not be mapped out. On the right side was a firm, movable mass about the size of the kidney, at the level of the umbilicus. The depth of the uterus was four and one-half inches. The curette brought away, through an os that readily admitted two fingers, considerable masses of tissue, which Dr. W. F. Whitney pronounced hyperplastic uterine mucous membrane. The diagnosis of fibroid was apparently confirmed by this examination, in so far as it was possible to make any diagnosis.

The hæmorrhage not being checked by the curetting, the patient was operated upon, and the following condition found: The left tube convoluted and twisted upon itself, and glued to the uterus, its cavity distended with puriform secretion, formed the mass on the left. On the right, the whole broad ligament spread over the intestines like the omentum, and was attached at the level of the umbilicus. The right tube was very much enlarged, holding about four to six ounces of puriform material. This kidney-shaped mass, which felt like a pediculated fibroid, the omentum and the apron-like broad ligament were firmly adherent throughout their extent, and the intestines were also matted together by both chronic and recent adhesions. The case was one of double purulent salpingitis and pelvic peritonitis.

Mrs. H. N. T., thirty-two. Mother of three children. Questionable miscarriage a year and one-half ago, at two months. Seen in June. Always been well previously until March, when it was supposed that she had an attack of malaria, as she had chills

and fever. These were accompanied by very little pain on the right side. In bed about half the time. In May a swelling was noticed on the right side; coincident with the appearance of this swelling, there was pain in the right leg along the course of the sciatic nerve, and pain which shot up along the course of the right ureter. The pain was so excessive as to demand frequent and large doses of morphia. Patient much emaciated; general condition very poor; occasionally a high temperature; most of the time the temperature very slightly elevated above normal. Depth of uterus between three and three and one-half inches. No catamenia since March, that is, three months. Had previously been entirely regular.

Under ether there could be felt an enlarged tube on the left side. On the right side there could be felt adhesions; and in the median line a mass about the size of the fœtal head at term — elastic, not distinctly fluctuating, not separated from the uterus, lying toward the right side, and on the anterior surface of the uterus. This tumor had increased somewhat in size since it was first discovered, but not rapidly. The diagnosis was between a uterine fibroid and salpingitis, with the preference rather in favor of the former from the relation of the mass to the uterine body. I operated the first of August, and found the mass overlying the uterus to be a tubo-ovarian abscess, densely adherent to the surrounding tissues. The ovary contained a cyst the size of a man's fist, into which the thickened tube opened freely; this cyst was filled with somewhat offensive pus. In consequence of the manipulations necessary to free it from its adhesions, tears were made into the rectum and into the tube, so that the pus escaped freely into the cavity of the rectum and the abdominal cavity. The rectal tear was stitched up by a continuous suture of fine silk. The left tube

was also freed from its adhesions and removed; it was enlarged to the size of the little finger and contained pus. The abdominal cavity was washed out and the patient made a perfect convalescence.

In this case it was impossible to say that the tumor felt before the operation was not fibroid. Its location, the symptoms caused by its presence, were all indicative of fibroid rather than salpingitis. The estimated contents of the two tubes was a pint in the right side, a half a pint in the left.

Results of removal of the uterine appendages in their influence upon menstrual disorders; reflex symptoms.

I operated during December, 1890, upon three cases to bring about cessation of the menstrual flow, and involution of the genito-uterine organs.

Miss G. C., school-teacher. Bed-ridden for two years; intense dysmenorrhœa; probably from the history, membranous dysmenorrhœa. Had been dilated, curetted, galvanized, undergone the rest cure, and, in fact, had every treatment that could be suggested, without relief. Removed both tubes and ovaries, which were reported by Dr. Whitney to show increase of cicatricial tissue in the ovaries; tubes slightly catarrhal. The patient has entirely recovered. Superintended and performed a housekeeper's work on a large farm where there were many boarders last summer, and is self-supporting in every way, and entirely free from abdominal pain at the present time.

Miss S. B. Associated with the dysmenorrhœa was intolerable backache and pain in the side. She had been attendant at the out-patient department for nearly four years pretty constantly. Uterus was retroflexed and strongly adherent. By one or two etherizations and manipulations the adhesions were broken up, and the uterus replaced; but it never

stayed long in its position. The shortening of the round ligament kept it in place six months; then it went backward, due to the traction of the unruptured adhesions, uniting the uterus and rectum. Both broad ligaments were shortened and thickened. The laparotomy showed that the reason for the falling backward of the uterus was not due to the stretching of the round ligaments, but to the fact that they had each ruptured at the uterine attachment, permitting the fundus to go backward. The patient is now very well; not strong as she will be, but gaining constantly. Her weight has increased from ninety-five to one hundred and fifteen pounds.

Miss K., thirty years of age. Always had dysmenorrhœa, which, during the past few years, has steadily increased, rendering her unable to perform her duties as nurse. Headache nearly constant, pain over each ovarian region, nausea. The inter-menstrual periods too short to permit complete recovery of strength. Previous treatment very thorough, including rest, galvanism, drainage of uterus.

Both Fallopian tubes and ovaries removed. Report, December, 1890: "The microscopical examination showed evidence of a former catarrhal salpingitis with cicatricial contraction in both tubes and ovaries." Convalescence uneventful. Since the operation the patient has performed her duties as nurse, and gained flesh and strength, suffers from no reflex phenomena and considers herself entirely well.

These three cases represent the favorable results which may be accomplished by this treatment; but, as I have always taken occasion to state, I never would advise removal of the uterine appendages to overcome symptoms on any account, unless these symptoms were acutely threatening, without first having the patient pass through preliminary palliative treatment of suitable duration and character.

Change, as of senile atrophy, rapidly following the removal of diseased ovaries.

Mrs. L. Was referred to me last December for operation, having a large rectocele and lacerated and sub-involuted uterus. On examination, I found in addition to these lesions, an ovarian cyst upon either side, which I removed by laparotomy, and which proved to be dermoid, and occupied, so far as could be determined, the entire structure of the ovary, consequently these must have formed rapidly, as her child was only eighteen months old at this time. She made a perfectly uninterrupted recovery, and was to report six months later for the plastic operation first advised. At that time there were such marked changes of atrophy occurring, that I deemed it best to wait until further time had elapsed to see if this operation could be avoided.

January, 1892, one year from the operation, I found atrophy of the uterus and the vagina, and a senile-vaginitis with its tendency toward adhesive inflammation, as marked as though she had normally passed the climacteric ten years.

Certain unexplained results; for example, decrease in tumors with subsidence of symptoms following laparotomies which were but little more than exploratory incisions.

Miss M. S., twenty; single; school-girl.

December 9, 1890. Previous history and family history both good. Three months ago had pain in both ovaries and lumbar region, coincidental with a profuse, greenish discharge from the vagina; frequent and painful micturition. The menstrual history is of interest. Before this, for a number of years, she had been regular, flow lasting four days, and requiring six

to eight towels. The first menstruation after this pain began lasted but one day and she used but one towel. The second appeared two weeks late, and then was brought on by medicine which her medical attendant gave her. The third was similarly late, but had appeared without the use of medicine or treatment.

The pains at first lasted about an hour, occurring only two or three times daily, without abdominal tenderness on pressure. These pains grew steadily worse, both in frequency and severity. Ten weeks ago these attacks were followed by fever, intense pain and abdominal soreness, necessitating confinement to bed, with indefinite, but large doses of morphia; a temperature varying from 102° to 104°, and very considerable bladder irritability.

I first saw the patient December 9, 1890. She had then been in bed ten weeks, and was more or less completely narcotized. Her temperature was 102°, abdomen very sore, slightly enlarged. The following day, under ether, I found by examination, that there was atresia of the vagina about two inches within the vulva, through which I could not insert an ordinary sound. Combined rectal and abdominal palpation showed a mass upon either side of the pelvis, dense, elastic, non-fluctuating, indistinct in its outlines, but extending, apparently, across the whole pelvis. I made a diagnosis of salpingitis and peritoneal adhesions. There was no vaginal discharge of moment, so that I restored the vagina, by curetting and dilating, to its normal dimensions. The posterior cul-de-sac was lacking, the cervix terminating abruptly the upper end of the vagina.

Rest in bed, and the employment of hot douches produced little effect upon the temperature, which continued fluctuating daily between 100° and 102°, with regularity. The patient's general condition seemed quite good, with this exception.

I operated January 2d. Through an incision of two inches it was found that the omentum was glued everywhere to the surface of the abdominal walls. The perineum was much thickened, and everywhere there were light, fresh adhesions which were easily separated. Deflecting the omentum upward and backward, there occurred a discharge of six to eight ounces of clear, serous fluid. There was no evidence of any cyst having been opened, but everywhere, as the finger was swept about, it encountered matted masses of intestines, which in part were easily separated, and the interstices of which were filled with fluid of encysted peritonitis. This line of pelvic peritonitis terminated sharply at the brim of the pelvis, above which were all the intestines except the rectum and some few matted and adherent coils of the smaller intestine.

The adhesions which bound these parts together were, as a rule, well organized and very strong. Many of them existed as long bands, notably one or two which seemed to stretch entirely from one side to the other of the pelvis like a piece of twine. These long bands were, as a rule, about as large as a lead pencil. The largest cavity that was opened, contained perhaps, about six ounces of serum. Multitudes of smaller cysts contained amounts varying from a few drops to an ounce or two.

There were two especially distinct masses to which the tubes could be traced, and which probably contained the ovaries, but an attempt to dissect these out to remove them, showed that the ureter on either side was also implicated in these masses, consequently, I terminated the operation by breaking down all the adhesions possible, by sponging out and rupturing all the cysts, and by replacing, as far as possible, the intestines in their normal position. Convalescence was

uninterrupted. Pain ceased from the time of the operation; temperature fell to normal, and remained there. Examination under ether, one month after the operation, showed that there was present two distinct masses; one on the right, about the size of a pigeon's egg, and one on the left, about the size of a hen's egg. The patient has reported from time to time, is perfectly well, going to school again, and menstruation has resumed its normal course.

Miss M., nineteen. Referred to me by Dr. Marion. Gives history of having passed through two severe attacks of pelvic inflammation, accompanied by high fever. It was supposed at that time that she had salpingitis. The last attack had been about two months before I saw her. There was a firm, dense, resisting mass to be felt, filling the left side of the pelvis, crowding the uterus to the right, very tender. The exploratory incision showed this to be a fibroid growth beneath the front of the broad ligament; its seat of attachment to the uterus occupying about two-thirds of the lateral surface of that organ; non-pediculated intramural. The broad ligament and uterus were so matted together, as the result of previous peritoneal attacks, that it seemed unwise to attempt the enucleation of the fibroid. The patient made a good recovery from the exploratory incision, has been able to resume her work, has declared that there is a noticeable decrease in the size of the mass, and that she is entirely free from pain, unless after very prolonged exercise, when she finds that the left side tires more easily than any other part. Exactly what local change, if any, has taken place here beyond that of freeing the adhesions, I am unable to say, but certainly the patient has practically received great benefit.